

**Comprehensive Health Home for the
Underserved Mentally Ill**
Family & Children's Service, INC.
Tulsa, OK

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Population(s) of Focus

- The program focuses on ensuring access for uninsured, indigent and low income adults with serious mental illness (SMI) to comprehensive primary medical and oral health care in Tulsa County, OK. Persons with SMI in Oklahoma die 30 years earlier on average than the general population, which is higher than national research data indicating that persons with SMI die 25 years earlier. There is also a 14-year difference in life expectancy between north Tulsa (high ratios of minorities and those living in poverty) and south Tulsa (lower rates of minorities and those living in poverty).
- The identified target population for the program has a much higher prevalence of preventable, co-occurring chronic diseases such as asthma, diabetes, cancer, heart disease and cardiopulmonary conditions. Often, persons with serious mental illness are not able to access primary care settings. Up to 70% of this population has at least one of these chronic health conditions, 45% have two, and almost 30% have three or more, making the co-occurrence of chronic medical disorders and complex health needs an expectation, not an exception.
- The target population for the program includes racially and ethnically diverse sub-populations with an identified need to focus on ensuring access, particularly for African American, Hispanic and Native American persons in need of integrated care.
- Based on our knowledge of the target population, the program targets the below identified access disparities for our sub-populations:
 1. The target population for the program includes racially and ethnically diverse sub-populations with an identified need to focus on ensuring access, particularly for African American, Hispanic and Native American persons in need of integrated care.
 2. There is a need for resources to assist in reducing or eliminating language barriers based on an early identification of access issues within our existing co-located clinic.
 3. High poverty rates among this population result in barriers to access, including transportation, stigma and mistrust of providers.

Implementation Practices

- The program is facilitated by the fact that both Family & Children Services and Morton Comprehensive Health Services (MCHS), have extensive experience in providing behavioral health and primary care to diverse racial/ethnic groups. Both organizations ensure that staff is trained in meeting the cultural and linguistic needs of the target population and all sub-populations. MCHS is located in north Tulsa and has a primary mission of ensuring access for minorities to quality health care.
- Program staff are focused on the individual and family's cultural, linguistic and racial identification as well as the uniqueness of each family. All staff receive specialized training in delivering culturally competent and effective services to diverse populations and low income, indigent and homeless consumers who present with both SMI and chronic health conditions. Training is supported by policies identifying services provided to consumers with cultural and/or linguistic special needs.
- Organizational services utilized to help address behavioral health disparities include:
 1. Linguistic (bi-lingual staff, internal Spanish interpreters and use of local resources including language line services);
 2. MCHS existing transportation system;
 3. Distribution of bus tokens, food pantry services and clothing closet;
 4. Linkage to community resources;
 5. Medical Assistance Program (MAP) – Local sponsors created access for the uninsured citizens of Tulsa County through a broad array of medical providers. MAP includes a network of primary care clinics, physician specialists and pharmacy programs.
 6. Prescription Assistance Program (PAP) - helps lower income patients afford their medications and serve as a single point of access to over 250 Patient Assistance Programs across the country.
 7. Health literacy and other communication needs are accommodated by providing a majority of reading material in the person's native language. Clients not able to read have all informed consents, treatment protocols, and case record forms read to them.

Challenges and Barriers

Initially, client access into the program was a challenge. The program's access criteria was primarily based upon the client's medical diagnosis. Behavioral Health staff do not have access to primary care electronic health record (EHR) resulting in limited healthcare information available to behavioral staff.

- We redefined our access criteria to include all uninsured clients who have fragmented or no access to health care services and not base client access upon medical diagnosis.
- Changing our access criteria increased our client engagement from 41 to 189 clients over an eight week period of time.

Data & Collection Measures

The program's data collection and outcomes is based on the following goals :

Goal 1: Integrate comprehensive primary and specialty medical services with behavioral health services in a community mental health center setting.

Goal 2: Improve the health status of SMI consumers with chronic disease through use of evidence-based care management practices.

Goal 3: Improve quality, access, and reliability of care by facilitating transitions of care and providing enhanced care coordination across the Medical Neighborhood.

Goal 4: Improve patient empowerment and self management.

Goal 5: Integrate health information technology into the Health Home setting at the provider/care team level.

Each goal has specific objectives with assigned benchmark goals based upon National Quality Forum (NQF) standards. Data is collected through the primary care EHR and MyHealth Access network systems. The health outcomes is reported as aggregated data based upon the total number of clients engaged in the program and compared to the benchmark goals set for each objective.

Successes to Date

- Changing our program access criteria has also changed our workflow processes in order to capture and engage the clients into the program. The workflow changes were brought about through a team effort that has resulted in an increase in client engagement and excitement from the team in seeing their ideas come to fruition in meeting the target client goal of 250 for grant year 2013.

As the clients become more engaged in their healthcare, the data is starting to show improved outcomes. An example is hypertension. The program's objective is to increase the percentage of patients, age 18-85 years, with a diagnosis of hypertension, and whose blood pressure was adequately controlled (<140/90). The benchmark for this objective is 60% . At the end of 3rd quarter, grant year 2013, we are currently at 64% of our clients have a blood pressure <140/90.

Looking Ahead

- We are currently looking at sustaining services for sub-populations through the FQHC partnership to create and present an innovation plan to CMS for an innovation grant.
- In grant year 2014 we are look at expanding services to a family clinic which may include a pediatric population resulting in greater financial resources to sustain services for the indigent and uninsured client population.